State of Rhode Island and Providence Plantations
Department of Human Services
Division of Health Care Quality, Financing and Purchasing

Request for Prior Authorization for Rehab/Adaptive Equipment

(The following information must be filled out only by the treating physician and/or therapist.

Name: _____

Weight: _____ **Height:** _____ **DOB:** _____

Requested Equipment (to include all accessories): _____

_____

_____

_____

_____

_____

Is this equipment replacing a similar piece of equipment? (If yes, please justify why the present equipment does not meet the recipient's needs): _____

_____

_____

_____

_____

_____

If this is a new piece of equipment, please detail why this equipment and all the accessories are required? _____

_____

_____

_____

_____

_____

What other equipment has been considered before deciding upon this equipment?

_____

_____

_____

Why was this product selected over that of another manufacturer? _____

_____

_____

_____

Has this equipment been tried in the recipient's home/auto for fit? _____

_____

_____

_____

Has this recipient tried this equipment (ie. loaner, demo)? If no, why not? _____

_____

_____

_____

Please use the following space to include any information that has not been previously stated. _____

_____

_____

_____

_____

_____

It is the opinion of the following individuals, that the requested equipment as stated above is beneficial for the care of this recipient:

_____ _____

(signature of treating physician) **(signature of recipient/parent/guardian)**

_____

(signature of treating therapist)